

HIV ANTIBODY TEST

CALIFORNIA STATE DEPARTMENT
OF HEALTH SERVICES

LOCAL LABORATORY NUMBER

Unique Office
of AIDS Client
Number



999-9999-9

SPECIMEN DATE:

(mm/dd/yy)

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RETURN APPOINTMENT

DATE: (mm/dd/yy)

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GENDER: ☐ (1) MALE ☐ (2) FEMALE ☐ (3) M-F ☐ (4) F-M

DATE OF BIRTH:

(mm/dd/yyyy)

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RESIDENCE COUNTY:

RESIDENCE ZIP CODE:

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LABORATORY NAME & ADDRESS:

CLINIC/SITE NAME, ADDRESS, & PHONE:

CONFIDENTIAL TESTING USE ONLY

LAST NAME:

SSN: (last 4 digits,
0000 if unknown)

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SOUNDEX CODE:

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RAPID TEST USE ONLY

LOT NUMBER:

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EXPIRATION
DATE: (mm/yy)

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COUNSELOR/
TECH INITIALS:

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SPECIMEN: ☐ (1) ORAL ☐ (2) FINGER STICK ☐ (3) VENIPUNCTURE

BEGIN TEST

END TEST

TIME TEMPERATURE

TIME TEMPERATURE

☐ AM

°

F

☐ AM

°

F

☐ PM

☐ PM

RESULT: ☐ (1) PRELIMINARY POSITIVE (indicate confirmatory specimen)

☐ (2) NEGATIVE

☐ (3) INVALID, reason: _____

CONFIRMATORY SPECIMEN GIVEN: ☐ (1) YES ☐ (2) NO

LAB SPECIMEN

SPECIMEN: ☐ (1) ORAL ☐ (2) FINGER STICK ☐ (3) VENIPUNCTURE

TEST SITE COPY

DHS 8257 (9/03)